Selskar House, Farnogue Residential Healthcare Unit

ID Number: AC0092

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Selskar House, Farnogue Residential Healthcare Unit
Old Hospital Road
Wexford

Conditions Attached: None

Approved Centre Type: Psychiatry of Later Life

Most Recent Registration Date: 2 May 2019

Registered Proprietor: HSE

Registered Proprietor Nominee: Mr David Heffernan, Acting Head of Services, CHO 5 Mental Health Services

Inspection Team: Susan O’Neill, Lead Inspector
Sarah Moynihan
Carol Brennan-Forsyth

Inspection Date: 23 – 26 July 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 29 May – 1 June 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Thursday 13 February 2020

2019 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

Chart 2 – Comparison of overall risk ratings 2017 – 2019
Contents

1.0 Inspector of Mental Health Services – Review of Findings .................................................. 5
2.0 Quality Initiatives .................................................................................................................. 9
3.0 Overview of the Approved Centre ...................................................................................... 10
   3.1 Description of approved centre ..................................................................................... 10
   3.2 Governance ..................................................................................................................... 10
   3.3 Reporting on the National Clinical Guidelines ......................................................... 12
4.0 Compliance .......................................................................................................................... 13
   4.1 Non-compliant areas on this inspection ................................................................. 13
   4.2 Areas of compliance rated “excellent” on this inspection ......................................... 13
   4.3 Areas that were not applicable on this inspection .................................................. 14
5.0 Service-user Experience .................................................................................................... 15
6.0 Feedback Meeting ............................................................................................................. 16
7.0 Inspection Findings – Regulations ..................................................................................... 17
8.0 Inspection Findings – Rules ............................................................................................. 52
9.0 Inspection Findings – Mental Health Act 2001 .............................................................. 54
10.0 Inspection Findings – Codes of Practice ....................................................................... 55
Appendix 1: Corrective and Preventative Action Plan ......................................................... 58
Appendix 2: Background to the inspection process .............................................................. 68
1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services  
Dr Susan Finnerty

In brief

Selskar House was situated on the ground floor within Farnogue Residential Healthcare Unit in Wexford. It was a modern purpose-built facility constructed in 2013 and accommodated 20 elderly residents in single rooms with en suite bathroom facilities. Clinical care was provided by the Psychiatry of Later Life team.

The approved centre had improved compliance with regulations, rules and codes of practice from 68% in 2018 to 77% in 2019. However, this level of compliance had decreased since 2017, when compliance was 84%. Eleven compliances with regulations were rated as excellent.

Conditions to registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

Safety in the approved centre

- Mandatory training completion rates had significantly improved compared to the previous year, but not all health professionals had up-to-date mandatory training in the areas of fire safety and Management of Therapeutic Violence and Aggression.
- Medication was ordered, prescribed, stored and administered in accordance with safe procedures.

However:

- The door mechanism that maintained many of the bedroom doors in an open position was broken. As a result, staff were observed to place a bin or chair in front of the door to maintain an open position. As the bedroom doors were active fire doors, such an obstruction would prevent door closure in the event of a fire.

Appropriate care and treatment of residents

- Each resident had a multi-disciplinary individual care plan (ICP) that was developed and reviewed as far as possible with the resident and their families.
• Therapeutic services and programmes were provided according to assessed needs and as outlined in the residents’ ICPs.

• Adequate arrangements were in place for access by residents to general health services and for their referral to other health services.

• Residents general health needs were monitored and assessed every six months or as indicated by the residents’ specific needs. Each assessment included a record of a physical examination, body mass index, weight, waist circumference, blood pressure, smoking status, and dental health. For residents, prescribed antipsychotic medication, there was an annual assessment of glucose regulation, blood lipids, prolactin levels and an electrocardiogram (ECG).

However:

• Physical assessments did not adequately document family or personal history, medication reviews, and nutritional status.

• In the case of one episode of physical restraint, a physical examination had not been carried out within the 3-hour time period specified in the relevant code of practice.

Respect for residents’ privacy, dignity and autonomy

• Each resident was appropriately dressed and as far as possible retained control over their own property and possessions.

• There were areas in the approved centre where residents could meet their visitors in private.

• Each resident had a single en suite bedroom.

• The approved centre was clean, hygienic, and free from offensive odours and a cleaning schedule was implemented within the approved centre.

However:

• The approved centre was not maintained in a good state of repair internally. Numerous maintenance issues were noted by the inspection team including stained flooring, faulty sink taps in two bedrooms, a peeling fire door seal, a cracked window pane, two broken shower screens, a missing wardrobe door, a broken bedroom window, a broken door handle and lock, and broken door hold back mechanisms on multiple bedroom doors. Some of these issues were already identified by the service and reported to the maintenance team; all other identified faults were reported during the inspection. The maintenance team response rate was extremely slow; many of the reported faults were awaiting repair for over three months.

Responsiveness to residents’ needs

• There had been an installation of Wi-Fi within the approved centre and the acquisition of an electronic tablet for the purposes of enhancing resident communication.

• Appropriate recreational activities were provided.
• Written and verbal information was provided about the approved centre and residents diagnoses and medication.
• There was a comprehensive complaints process in place.
• Noticeboards did not detail resident names or other identifiable information. All bathrooms, showers, toilets and single bedrooms had locks on the inside of the door that had an override function. Where bedroom doors had an observation window, a blind was fitted on the exterior of the door.

However:

• Phone calls were facilitated using a landline phone at the reception area which was not conducive to maintaining privacy.
• In one bedroom, it was noted that the window was broken, allowing a cold draft to enter the bedroom and causing the resident discomfort. The window was broken for several months in spite of reporting to the maintenance team.
• The dining room was observed to be too small for the current resident population and profile. Some of the residents required staff assistance with feeding. Due to space limitations, staff were unable to be seated opposite the resident, and were required to stand over the resident during mealtimes. In addition, two residents had to eat their meals at a table situated on the corridor opposite the dining room due to lack of space.

**Governance of the approved centre**

• The approved centre was under the governance of the Waterford/Wexford Mental Health Services and within the overall governance of the South East Community Healthcare Organisation. At an area level, governance structures included an Executive Management Committee (EMT) and a Quality and Safety Executive Committee. At a local level, a multi-disciplinary Quality and Patient Safety Committee (QPSC) met on a bimonthly basis.
• There was no formal in-service training programme; however, relevant training sessions were scheduled as needs were identified and two staff members were undertaking postgraduate courses.
• The local risk register included clinical risks, health and safety risks, and structural risks. Overall, the approved centre had satisfactory processes for the assessment, treatment and monitoring of risks; however, not all risks were effectively identified.
• Quality improvement issues were consistently reviewed by the multi-disciplinary team at the bimonthly Quality and Patient Safety Committee meetings. There was a programme of audit; however, the multi-disciplinary team were not involved and the majority of audits were undertaken by the nursing team.
• At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement.
However:

- Monitoring of individual and team performance was poorly defined across the majority of disciplines. Formal staff appraisals were not undertaken within any of the disciplines, however supervision sessions with line management were completed for the majority of disciplines.

- While faults in the environment had been reported to the maintenance team many months previous, they were still not addressed. Other identified faults were not reported at all. Although issues concerning the responsiveness of the maintenance team were repeatedly discussed at the local Quality and Patient Safety meetings, this had not translated into a responsive and effective maintenance service at Selskar House. The general lack of progress contributed to a sense of resignation and acceptance of this situation amongst staff. At the time of inspection, these issues had not been escalated to the area Quality and Safety Executive Committee.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Five staff members trained in auditing procedure.

2. Introduction of a new physical restraint checklist to help ensure all necessary processes are adhered to.

3. Revised proforma documentation to support the process of resident transfer to another facility.

4. Installation of Wi-Fi within the approved centre and acquisition of an electronic tablet for the purposes of enhancing resident communication.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

Selskar House was situated within Farnogue Residential Healthcare Unit, a modern purpose-built facility constructed in 2013. Selskar House occupied the ground floor of this facility. Selskar House accommodated 20 residents in single rooms with en suite bathroom facilities. There were no involuntary patients, none of the resident were on approved leave, and there were no wards of court. The residents were under the care of the Psychiatry of Later Life team.

The approved centre was spacious and bright. There were two internal courtyard areas used by residents throughout the day. There was also an enclosed garden area and supervised access to the garden was facilitated by the nursing team as appropriate. Within the approved centre, there was suitable areas for recreational activities and visiting. An oratory was situated on the ground floor of Farnogue Residential Healthcare Unit and this was accessible to residents of the approved centre.

The resident profile on the first day of inspection was as follows:

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>20</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>20</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>19</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was under the governance of the Waterford/Wexford Mental Health Services and within the overall governance of the South East Community Healthcare Organisation. At an area level, governance structures included an Executive Management Committee (EMT) and a Quality and Safety Executive Committee. Committee meetings were attended by heads of service or discipline and the EMT meeting was also attended by the Area Lead for Mental Health Engagement. At a local level, a multidisciplinary Quality and Patient Safety Committee (QPSC) met on a bimonthly basis. An organisational chart which identified the lines of authority and accountability within the approved centre was documented.

The Mental Health Commission’s Governance Questionnaire was issued to the approved centre’s heads of discipline in advance of the inspection. Four completed questionnaires were returned; Occupational Therapy Manager, Principal Psychologist, Area Director of Nursing and Service Manager. The questionnaires outlined regular engagement with staff and clear lines of responsibility. Operational risks included staff shortages, access to mandatory training resources, and inadequate space for the purposes of assessment and
treatment. Monitoring of individual and team performance was poorly defined across the majority of disciplines. Formal staff appraisals were not undertaken within any of the disciplines, however supervision sessions with line management were completed for the majority of disciplines. At the time of inspection, the post of principal social worker was vacant. As a consequence, the social worker within the approved centre was line managed by the Service Manager; however, external social work supervision for this employee was organised. This issue was under review by the Quality and Safety Executive Committee.

A local induction programme was undertaken for all new staff commencing employment within the approved centre. There was no formal in-service training programme; however, relevant training sessions were scheduled as needs were identified. Opportunities for further education were made available to staff and at the time of inspection two staff members were undertaking postgraduate courses. Staff training plans were completed to identify required mandatory training; however, records indicated that not all health professionals had up-to-date mandatory training in the areas of fire safety and Management of Therapeutic Violence and Aggression. Mandatory training completion rates had significantly improved compared to the previous year.

In January 2019, a local risk register was developed and introduced to the service. The register was reviewed in March by the risk advisor and senior nursing management; the next review was due in July 2019. The risk register included clinical risks, health and safety risks, and structural risks. Actions were identified for the removal or effective mitigation of structural risks. At the time of inspection, none of the existing risks on the register had been escalated to the area risk register.

Overall, the approved centre had satisfactory processes for the assessment, treatment and monitoring of risks; however, not all risks were effectively identified. Upon inspection, the door mechanism that maintained many of the bedroom doors in an open position was broken. As a result, staff were observed to place a bin or chair in front of the door to maintain an open position. As the bedroom doors were active fire doors, such an obstruction would prevent door closure in the event of a fire. While staff were aware of the faulty mechanism, there was no insight that this issue led to practices that contravened fire risk management procedures. Effective identification of risk required an integrated approach between the clinical and maintenance team to ensure a combination of skills and expertise. In this case however, monthly surveys of the premises for purposes of identifying maintenance issues and related risks were undertaken by nursing management alone.

Upon inspection, several maintenance issues were noted by the inspection team. While some of these faults had been reported to the maintenance team many months previous, they were still not addressed. Other identified faults were not reported at all; however, these were reported by the management team during the inspection. Since August 2018, issues concerning the responsiveness of the maintenance team were consistently discussed at the local Quality and Patient Safety meetings. In spite of measures implemented to improve availability of maintenance services, this had not translated into a responsive and effective maintenance service at Selskar House. The general lack of progress contributed to a sense of resignation and acceptance of this situation amongst staff. At the time of inspection, these issues had not been escalated to the area Quality and Safety Executive Committee.

Quality improvement issues were consistently reviewed by the multidisciplinary team at the bimonthly Quality and Patient Safety Committee meetings. Other systems in place to support quality improvement
included a programme of audit; however, the multidisciplinary team were poorly integrated in this respect, and the majority of audits were undertaken by the nursing team.

At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement. Feedback was integrated into quality and safety improvement activities undertaken by the multidisciplinary team.

### 3.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.
4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>Low</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Use of Physical Restraint in Approved Centres</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 14: Care of the Dying</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents’ feedback about the approved centre.

With the residents’ permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents’ experience of the approved centre as outlined below.

One resident met with the inspection team and discussed their experience living in the approved centre. There were no significant issues raised by this resident.
6.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Acting Clinical Director
- Service Manager
- Deputy Manager
- Area Director of Nursing
- Consultant Psychiatrist
- Acting Clinical Nurse Manager, Grade 3
- Assistant Director of Nursing
- Risk Advisor
- Chief Officer of South East Community Healthcare
- Occupational Therapy Manager
- Principal Psychologist
- Social Worker

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.
EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions
Regulation 4: Identification of Residents

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in April 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: The approved centre used a minimum of two person specific resident identifiers that were appropriate for the resident’s communication abilities. Identifiers used included name, date of birth, address and photograph. Two resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. Where residents with the same or similar name were admitted to the approved centre, a red sticker alert system was in operation.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 5: Food and Nutrition

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident’s individual care plan.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in July 2018. The policy addressed all requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Hot and cold drinks were offered to residents regularly. Hot meals were provided on a daily basis and resident had at least two choices for meals. Food, including modified consistency diets, were presented in a manner that was attractive and appealing in terms of texture, flavour and appearance. There was a source of safe, fresh drinking water available to residents at all times.

The Malnutrition Universal Screening Tool, an evidence-based nutrition assessment tool, was used in the approved centre. Where appropriate, weight charts were implemented, monitored and acted upon for residents. Residents could be referred to a dietitian as required. Intake and output charts were maintained for residents where appropriate.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 6: Food Safety

(1) The registered proprietor shall ensure:
   (a) the provision of suitable and sufficient catering equipment, crockery and cutlery
   (b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and
   (c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:
   (a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
   (b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
   (c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in March 2019. The policy included all any of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Catering areas and associated equipment were appropriately clean. Handwashing facilities and protective equipment were available within catering areas. Hygiene was maintained to support food safety requirements.

All food was prepared off site and transported to the approved centre. There were proper facilities for the refrigeration, storage, and serving of food within catering areas. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 7: Clothing

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident’s individual care plan.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in April 2018. The policy included all any of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents’ clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: All residents had an adequate supply of clean and individualised clothing. Residents were supported to keep and use personal clothing. Residents changed out of night clothes during daytime hours unless specified in the resident’s individual care plan. If required, residents were provided with emergency clothing that was appropriate to the resident and considered the residents’ preferences, dignity, bodily integrity, and religious and cultural preferences.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 8: Residents’ Personal Property and Possessions

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents’ personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident’s personal property and possessions and is available to the resident in accordance with the approved centre’s written policy.

(4) The registered proprietor shall ensure that records relating to a resident’s personal property and possessions are kept separately from the resident’s individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident’s individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in June 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents were supported to manage their own property, unless this posed a danger to the resident or others. A safe was located in the clinical nurse manager’s office for the secure storage of resident monies and valuables. The approved centre compiled a detailed property checklist with each resident on admission listing their personal property and possessions. The checklist was stored within the resident’s clinical file. The access to and use of resident monies was not always overseen by two members of staff and the resident or representative. Cash lodgement and withdrawal records were not always signed by two staff members or countersigned by the resident or their representative where possible.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillars.
Regulation 9: Recreational Activities

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in June 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake and attendance. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile both on weekdays and on weekends. Information detailing the scheduling and types of different activities was not provided within the approved centre. The recreational activity programme was developed and implemented with resident involvement. The programme was appropriately resourced and provided opportunities for indoor and outdoor exercise and physical activity.

Not all communal areas were suitable for the provision of recreational activities. Various activities took place within the sun room and the sitting room; however, the art group was held at a disused nurse’s station on the corridor. This was not ergonomically suitable for the resident group profile. Documented records of resident attendance were retained for recreational activities. Each resident’s decision on whether to participate in activities was respected.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
Regulation 10: Religion

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2019. The policy included all of the requirements of the Judgement Support Framework.

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

**Monitoring:** The implementation of the policy to support residents’ religious practices was reviewed to ensure that it reflected the identified needs of residents. This was documented.

**Evidence of Implementation:** Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. A multi-denominational prayer room was located on the ground floor of Farnogue Residential Healthcare facility and residents within the approved centre were assisted by staff to access this room as required. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. Care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values. The resident was facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent as the approved centre met all criteria of the Judgement Support Framework.
Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits. The policy was last reviewed in September 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: There were no restrictions on residents’ rights to receive visitors. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate and reasonable. Visiting times were publicly displayed within the approved centre. Visiting areas were provided where residents could meet visitors in private, unless there was an identified risk to the resident or to others. Visiting areas were suitable for visiting children. Children were accompanied at all times to ensure their safety. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 12: Communication

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in January 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, e-mail, internet, telephone, or any device for the sending or receiving of messages at all times. At the time of inspection, there were no identified risks associated with any resident’s external communication.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in May 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

There were no searches conducted in the approved centre since the last inspection, therefore the approved centre was assessed under the two pillars of processes and training and education only.

The approved centre was compliant with this regulation.
Regulation 14: Care of the Dying

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was last reviewed in July 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: Three expected deaths had occurred in the approved centre since the last inspection. The clinical file of one resident was inspected. The end of life care provided was appropriate for the resident’s physical, emotional, social, psychological and spiritual needs. Pain management was prioritised during end of life care. Religious and cultural practices were respected. Advanced directive relating to end of life care, as well as associated documentation were evidenced within the clinical file.

The privacy and dignity of the resident was protected. The resident was nursed in a single room during the provision of end of life care. Representatives, family, next of kin and friends were involved and supported during end of life care. Support was given to other residents and staff following the resident’s death. Notification of the resident’s death was sent to the Mental Health Commission within 48 hours.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 15: Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan: “...a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation.”]

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Residents’ ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Ten ICPs were inspected. Each ICP was a composite set of documents contained within the clinical file and separate from the progress notes. Each resident was assessed upon admission and an initial care plan was completed by the admitting clinician. An ICP was then developed by the MDT following comprehensive assessment within seven days of admission. This assessment included medical, psychiatric and social history, medication history, current physical health assessment, a detailed risk assessment, social and interpersonal issues, and communication abilities. The assessment did not include details on educational, occupational and vocational history.

The ICP was discussed, agreed and drawn up with the participation of the resident and their representative as appropriate. The ICP identified appropriate needs and goals for each resident. The ICP also identified the care, treatment and resources required to meet those goals. The ICP was reviewed and updated by the MDT, in consultation with the resident, at least every six months. The resident had access to the ICP and was offered a copy of the care plan, including any reviews.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 16: Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in May 2018. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The planning and provision of therapeutic services and programmes within the approved centre
- The provision of therapeutic services and programmes by external providers in external locations.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: Therapeutic services and programmes provided by the approved centre were appropriate and met the needs of the residents. All therapeutic services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Noticeboards within the approved centre displayed lists of all therapeutic services provided. Where a resident required a therapeutic service that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified professional.

Adequate and appropriate resources were available to provide therapeutic services. The approved centre did not have a dedicated therapy room for individual and group therapeutic activities; however, the sitting room was used for this purpose. A record was maintained of participation, engagement, and outcomes achieved in therapeutic activities within the resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 18: Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: An assessment of the resident was completed prior to transfer, including an individual risk assessment relating to the transfer and the resident’s needs. The resident was transferred to another facility in an emergency situation; however, communication between the approved centre and the receiving facility was documented and followed up with a written referral. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. Copies of all records relevant to the resident transfer process were retained in the resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 19: General Health

(1) The registered proprietor shall ensure that:
   (a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
   (b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
   (c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

INSPECTION FINDINGS

Processes: The approved centre had written operational policy in relation to the provision of general health services and the response to medical emergencies which was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre did not have an emergency trolley but did have an automated external defibrillator (AED). Weekly checks were completed on the AED. Records were available of any medical emergency that occurred within the approved centre and the care implemented.

Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents general health needs were monitored and assessed every six months or as indicated by the residents’ specific needs. The general health assessments of five residents were inspected. Each assessment included a record of a physical examination, body mass index, weight, waist circumference, blood pressure, smoking status, and dental health. All five of the assessments did not adequately document family or personal history, medication reviews, and nutritional status. For residents, prescribed antipsychotic medication, there was an annual assessment of glucose regulation, blood lipids, prolactin levels and an electrocardiogram (ECG).

Adequate arrangements were in place for access by residents to general health services and for their referral to other health services. Residents had access to national screening programmes that were available according to age and gender. Information booklets and leaflets were provided to residents on national screening programmes.

The approved centre was non-compliant with this regulation because five of the six-monthly general health assessments reviewed did not adequately document the following: family or personal history, nutritional status, and medication review, 23(1)(b).
(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident’s multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

**INSPECTION FINDINGS**

Processes: The approved centre had a written policy in relation to the provision of information to residents. The policy was last reviewed in May 2018. The policy and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents received an information booklet upon admission that detailed the care and services available. The booklet contained details on the housekeeping arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, advocacy and voluntary agencies, residents’ rights, and the multidisciplinary team.

Residents were provided with written and verbal information regarding their diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition. Medication information sheets, as well as verbal information, was provided in a format that was appropriate to the resident’s needs. The information sheets included information on indications for use of all medications including any possible side-effects. All information provided by the approved centre was evidenced based and appropriately reviewed and approved prior to use.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 21: Privacy

The registered proprietor shall ensure that the resident’s privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in July 2018. The policy included all of the requirements of the Judgement Support Framework. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Staff members were observed to treat all residents in a respectful and friendly manner. Staff appearance and dress was appropriate. Staff exhibited discretion when discussing a resident’s condition or treatment needs. All residents wore appropriate and clean clothing.

Noticeboards did not detail resident names or other identifiable information. All bathrooms, showers, toilets and single bedrooms had locks on the inside of the door that had an override function. Where bedroom doors had an observation window, a blind was fitted on the exterior of the door. The blind opening and closing mechanism, however, allowed non-staff to operate the blind freely. Phone calls were facilitated using a landline phone at the reception area which was not conducive to maintaining privacy.

The layout, structural fittings and furnishings were not always conducive to resident dignity. In one bedroom it was noted that the window was broken, allowing a cold draft to enter the bedroom and causing the resident discomfort. The window was broken for several months in spite of reporting to the maintenance team. Another issue concerning the layout of the approved centre concerned the size of the dining room. The dining room was observed to be too small for the current resident population and profile. Some of the residents required staff assistance with feeding. Due to space limitations, staff were unable to be seated opposite the resident, and were required to stand over the resident during mealtimes. In addition, two residents had to eat their meals at a table situated on the corridor opposite the dining room due to lack of space.

The approved centre was non-compliant with this regulation for the following reasons:

a) One resident’s bedroom window was broken and the resulting draft caused the resident discomfort.
b) Staff were observed to stand over residents to assist with feeding at mealtimes.
c) Two residents had to eat their meals at a table on the corridor across from the dining room due to lack of space.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in July 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre had adequate heating, ventilation and lighting in all rooms. Sufficient space was provided for residents to move around, both indoors and outdoors. Outdoor spaces included a large courtyard which residents could access freely and a garden where access by supervised by staff. In general, residents had access to personal space, however, the dining room was too small to accommodate all residents, thus restricting personal space during mealtimes. The lack of space necessitated staff to stand over some of the residents whilst assisting them with feeding as there was no space to sit opposite the resident. In addition, two residents were observed to eat their meals at a table on the corridor opposite the dining room.

The approved centre was clean, hygienic, and free from offensive odours. A cleaning schedule was implemented within the approved centre. Current national infection control guidelines were followed. Hazards, including large open spaced, steps and stairs, slippery floor, hard and sharp edges and hard or rough surfaces, were minimised in the approved centre. Ligature points were not minimised to the lowest practicable level. The approved centre was not maintained in a good state of repair internally. Numerous maintenance issues were noted by the inspection team including stained flooring, faulty sink taps in two
bedrooms, a peeling fire door seal, a cracked window pane, two broken shower screens, a missing wardrobe door, a broken bedroom window, a broken door handle and lock, and broken door hold back mechanisms on multiple bedroom doors. Some of these issues were already identified by the service and reported to the maintenance team; all other identified faults were reported during the inspection. The maintenance team response rate was slow; many of the reported faults were awaiting repair for over three months.

All bedrooms were en suite and there were two communal toilets for residents to use on the main corridors, one of which was located close to the dining room. All toilets were wheelchair accessible, including the public toilet located beside the reception area across from the approved centre entrance. The approved centre had a designated sluice room, cleaning room and laundry room. There was no dedicated examination room. The approved centre did not provide suitable furnishings to support resident independence and safety. Many of the bedroom door hold back mechanisms were broken which resulted in most bedroom doors remaining in a closed position. Bedroom doors were heavy to open thereby impeding access for residents with walking aids or other mobility problems. Some of the doors were observed to be held open using a chair or bin during the inspection. As bedroom doors were active fire doors, this posed a fire risk on the premises.

The approved centre was non-compliant with this regulation for the following reasons:

a) The premises had not been maintained in good structural and decorative condition, 22(1)(a).
b) The approved centre did not have a suitably sized dining room to accommodate the number and mix of residents, 22(4).
c) The approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff, and visitors, as many of the bedroom door hold back mechanisms were broken, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in October 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten MPARs were inspected. All entries to the MPAR were legible and written in black indelible ink. Each MPAR was labelled with two appropriate resident identifiers. There was dedicated space within each MPAR for routine medications, once off medications, and as required medications. The generic name of each medication and preparation was used in all MPARs. Each MPAR recorded any allergies, doses to be administered, the administration route, the date of initiation and discontinuation of each medication, the prescriber’s signature for each entry, and the medical council registration number of every medical practitioner prescribing medication to the resident. A record of all medications administered to the resident and any medications refused or withheld was maintained.

All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with directions of the prescriber and any advice provided by the resident’s pharmacist. The expiration date of the medication was checked prior to administration. Direction to crush medication was only accepted from the resident’s medical practitioner, documented in the resident’s MPAR, and a reason for crushing recorded in the resident’s clinical file.

Medications were stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where Medication requires refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests, and free from spillage or breakage. Medication dispensed to the resident was stored securely in a locked drug trolley which was secured in a locked room. Scheduled 2 and
3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

A system of stock rotation was implemented to avoid accumulation of old stock. An inventory of medication was conducted on a monthly basis which checked the name and dose of medication, quantity of medication, and expiry dates. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication and returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and monitoring pillars.
Regulation 24: Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the health and safety of residents, staff, and visitors which was last reviewed in March 2019. It also had an associated safety statement dated January 2019. The policy and safety statement addressed requirements of the Judgement Support Framework, with the exception of the specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy.

Monitoring: The health and safety policy was monitored pursuant to Regulation 29: Operational Policies and Procedures.

Evidence of Implementation: Regulation 24 was only assessed against the approved centre’s written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.
Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in March 2019.

The policy did not address the following:

- The use of agency staff
- The process for reassignment of staff in response to changing resident needs or staff shortages

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. A planned and actual staff rota, showing the staff on duty at any one time during the day and night was maintained in the approved centre. The numbers and skill mix of staff was sufficient to meet resident needs. Staff were recruited and selected in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency.

An appropriately qualified staff member was on duty and in charge at all times. There was a written staffing plan for the approved centre which addressed the size and layout of the approved centre, the level of acuity of psychiatric illness, the age profile of residents and the number of beds available, physical health needs. The staffing plan did not include the length of stay of residents. The staffing plan was formulated on in the context of nursing staff only and did not reference other disciplines.
Opportunities were made available to staff by the approved centre for further education. At the time of inspection two staff nurses were undertaking postgraduate courses with the support of the service. In service training was completed by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training. The Mental Health Act 2001, the associated regulation and the Mental Health Commission Rules and Codes were available to staff throughout the approved centre.

All health care professionals were trained in Basic Life Support, the Mental Health Act 2001 and Children First. Not all nursing and medical professionals were trained in the Management of Violence and Aggression and fire safety.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (18)</td>
<td>18</td>
<td>100%</td>
<td>17</td>
<td>94%</td>
<td>15</td>
</tr>
<tr>
<td>Consultant Psychiatrist (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Medical (1)</td>
<td>1</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>1</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (1)</td>
<td>1</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
</tbody>
</table>

The following is a table of clinical staff assigned to the approved centre.

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selskar House</td>
<td>CNM2 or CNM 3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.4 WTE</td>
<td></td>
</tr>
</tbody>
</table>

Social Work and Psychology Service available on referral basis.

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Whole time equivalent (WTE)

The approved centre was non-compliant with this regulation because not all staff had up-to-date mandatory training in fire safety and PMAV, 26(4).
Regulation 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.


Note: Actual assessment of food safety, health and safety and fire risk records is outside the scope of this Regulation, which refers only to maintenance of records pertaining to these areas.

INSPECTION FINDINGS

Processes: The approved centre had a written policy/written policies and procedures in relation to the maintenance of records. The policy was last reviewed in May 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents’ records.
- Record retention periods.
- The destruction of records.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff had been trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All records were physically stored together securely in a locked nurses office which was only accessible to authorised staff. A record was initiated for every resident within the approved centre and maintained using an identifier that was unique to the resident. Records were developed and maintained to a logical sequence. All records were written legibly in black, indelible ink.

Records were not maintained in good order and loose pages were observed in one file. Records were not always consistent or reflective of the resident’s status. In one clinical file, it was noted that the dates recorded for review of mechanical restraint in one section did not correspond with the dates in a separate section of the file. Records were not always dated, timed or followed by a signature. A signature log was maintained by the approved centre, however it did not record signatures of professionals documenting within the clinical file.
Where an error was made within the file, this was corrected appropriately. Records were retained or destroyed in accordance with legislative requirements. Documentation of food safety, health and safety and fire inspection was maintained by the approved centre.

The approved centre was non-compliant with this regulation for the following reasons:

Records were not maintained in good order to ensure completeness, accuracy and ease of retrieval as:

a) Not all records had secure pages, 27(1).
b) Not all entries included the date, 27(1).
c) Not all entries included an accurate date, 27(1).
d) Not all entries included the time, 27(1).
e) Not all entries included a signature, 27(1).
Regulation 28: Register of Residents

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.
Regulation 29: Operating Policies and Procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in June 2017. It included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

**Monitoring:** An annual audit had been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

**Evidence of Implementation:** The operating policies and procedures of the approved centre were developed by the South East Community Healthcare Policy, Procedure, Protocols and Guidelines group; membership of the group consisted of clinical and managerial staff and other relevant stakeholders. Operating policies and procedures incorporated relevant legislation, evidence-based best practice and clinical guidelines. All operating policies were appropriately approved and communicated to relevant staff.

The format of all policies and procedures was standardised. Where generic policies were used, the approved centre had a written statement to this effect. All operating policies and procedures were reviewed by the policy group within a three year timeframe.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.
Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident’s individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the management of complaints. The policy was last reviewed in May 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policy. All interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: The complaints log indicated that there were no complaints or minor complaints since the 2017 inspection and so there was no audit completed.

Evidence of Implementation: There was a nominated complaints person dealing with complaints and their contact details were displayed within the approved centre. Residents and their representative were facilitated to make complaints using the methods detailed in the complaints policy and procedure, which included verbal, written, email, telephone and through complaint feedback and suggestion forms. The approved centre’s management of the complaint process was well publicised and accessible to residents and their representatives. Information about the complaint procedure was provided to the resident upon admission or soon thereafter. Information was documented within the residential information booklet.

A minor complaints log was maintained within the approved centre; all minor complaints were documented. All complaints, whether oral or written, were investigated promptly and handled appropriately. Where minor complaints could not be addressed locally, this was escalated to the nominated person. Since the previous inspection, no formal complaints had been lodged to the nominated complaints person.
The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in July 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. All clinical staff were trained in individual risk management processes. Management were not trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was known by all staff. Clinical, health and safety, structural, and corporate risks were identified, assessed, treated and monitored. These were
documented in the local risk register as appropriate. Not all health and safety risks, however, were identified. The hold open mechanism of many of the fire doors was broken, and as a result, some doors were observed to be held open using a chair or bin placed in front of the door. As bedroom doors were active fire doors, this practice posed a risk in the event of a fire on the premises.

Individual risk assessments were completed prior to and during physical restraint, mechanical restraint, admission to the approved centre, resident transfer to another facility, and resident discharge. Multidisciplinary team members were involved in the development, implementation and review of the individual risk management processes. Residents and representatives were involved in the individual risk management processes.

Incidents were recorded and risk rated in a standardised format. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service. The approved centre provided six monthly summary reports of all incidents to the Mental Health Commission, in line with the Code of Practice on the Notification of Deaths and Incident Reporting. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because the approved centre did not ensure that all health and safety risks were adequately identified. Active fire doors were obstructed, preventing closure, 32(1).
Regulation 33: Insurance

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre’s insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer’s liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.
Regulation 34: Certificate of Registration

The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

**INSPECTION FINDINGS**

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently.

The approved centre was compliant with this regulation.
8.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
**Section 69: The Use of Mechanical Restraint**

**Mental Health Act 2001**

**Bodily restraint and seclusion**

**Section 69**

(1) “A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section “patient” includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient.

**INSPECTION FINDINGS**

**Evidence of Implementation:** Mechanical restraint for an enduring risk of harm to the self or others was only used to address an identified clinical need. Mechanical restraint was only used when less restrictive alternatives were unsuitable. Mechanical restraint was ordered by a registered medical practitioner under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf. The clinical files contained contemporaneous records that specified the following: an enduring risk of harm to the self or others; less restrictive alternatives implemented without success; the type of mechanical restraint being used; the situation in which mechanical restraint was being applied; the duration of the restraint; and the duration of the order; the review date.

**The approved centre was compliant with this rule.**
Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable during the inspection. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: “prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

The Mental Health Act, 2001 (“the Act”) does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
Use of Physical Restraint

Please refer to the Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated June 2019. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: There was only one episode of physical restraint (PR) since the previous inspection. Physical restraint was only used in rare, exceptional circumstances and best interests of the resident, where the resident posed immediate threat of serious harm to self or others. Physical restraint was only used based on risk assessment and after all alternative interventions to manage the resident’s unsafe behaviour had been considered.

Physical restraint was initiated by a registered nurse in accordance with the policy on physical restraint. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified as soon as was practicable. A medical examination was not completed by a registered medical practitioner within three hours after the start of the episode of physical restraint. A medical examination did occur five days later upon detection of this error. A clinical practice form was completed by the person initiating the use of PR and placed in the resident’s clinical file; this was signed by the CP within 24 hours. The episode of PR was reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode.

The approved centre was non-compliant with this code of practice because a medical examination of the resident was not completed no later than three hours after the start of the episode of physical restraint, 5.4.
Admission, Transfer and Discharge

Please refer to the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge

Admission: The admission policy, which was last reviewed in October 2018, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, and discharge policies.

Evidence of Implementation:

Admission: Admission was on the basis of mental illness or mental disorder. An admission assessment was completed, and included the following: the presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, current mental health state, risk assessment, full physical examination, and any other relevant information. The resident’s family member/carer/advocate was involved with the admission process, with the resident’s consent.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The discharge plan included the estimated date of discharge, a follow-up plan, a reference to early warning signs of relapse and risks, and documented communication with the relevant general practitioner, primary care team or community mental health team. The discharge assessment addressed the resident’s psychiatric and psychological needs, current mental state examination, a comprehensive risk assessment and risk management plan, social and housing needs, and informational needs. A comprehensive discharge summary was issued within 14 days. The summary included details of the resident’s diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse. Family members were involved in the discharge process where appropriate.

The approved centre was compliant with this code of practice.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 19 General Health

<table>
<thead>
<tr>
<th>Reason ID : 10000714</th>
<th>Five of the six-monthly general health assessments reviewed did not adequately document the following: family or personal history, nutritional status, and medication review, 23(1)(b).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>The General Health Assessment Form as uploaded has been amended to include the following: Personal/Family (Medical) History Physical Activity Level within the Nutritional Status box and Non Psychotropic Medication Review has been changed to Medication Review. The revised form has been implemented as of July 2019 and when completed in full will address the inadequate documentation of family or personal history, nutritional status, and medication review. Bi annual General Health audits will take place to ensure adequacy of documentation on general health assessment forms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Action</td>
<td>Bi annual General Health audits will take place to ensure adequacy of documentation on general health assessment forms. Where forms are found not to be adequately completed, they will be completed in full.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
</tr>
<tr>
<td>Preventative Action</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bi annual General Health audits will take place to ensure adequacy of documentation on general health assessment forms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Achievable/Realistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievable/Realistic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADON/G.P.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Achievable/Realistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievable/Realistic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADON/G.P.</td>
</tr>
</tbody>
</table>
## Regulation 32: Risk Management Procedures

<table>
<thead>
<tr>
<th>Reason ID : 10000715</th>
<th>The approved centre did not ensure that all health and safety risks were adequately identified. Active fire doors were obstructed, preventing closure, 32(1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The faulty mechanisms to hold fire doors open have now been repaired. The ADON carried out briefing sessions with all staff to ensure fire doors are never obstructed. Daily monitoring to ensure fire doors are not obstructed takes place and monthly ADON Premises Audit checks all mechanisms for holding fire doors open are in working order. All faults identified are immediately reported and escalated to Service Manager if not repaired within an appropriate time frame.</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>The faulty mechanisms to hold fire doors open have now been repaired. The ADON carried out briefing sessions with all staff to ensure fire doors are never obstructed. Daily monitoring to ensure fire doors are not obstructed takes place and monthly ADON Premises Audit checks all mechanisms for holding fire doors open are in working order. All faults identified are immediately reported and escalated to Service Manager if not repaired within an appropriate time frame.</td>
<td>Daily monitoring to ensure fire doors are not obstructed takes place and monthly ADON Walkabout checks all mechanisms for holding fire doors open are in working order.</td>
</tr>
</tbody>
</table>

| Preventative Action | Daily monitoring to ensure fire doors are not obstructed takes place and monthly ADON Premises Audit checks all mechanisms for holding fire doors open are in working order. All faults identified are immediately reported and escalated to Service Manager if not repaired within an appropriate time frame. A new Maintenance Resolution Template has been implemented to record, and track resolution of maintenance issues | Daily monitoring to ensure fire doors are not obstructed takes place and monthly ADON Walkabout checks all mechanisms for holding fire doors open are in working order. | Achievable/Realistic | 07/01/2020 | CNM/ADON/Service Manager/Technical Services |

AC0092 Selskar House, Farnogue Residential Healthcare Unit  
Approved Centre Inspection Report 2019  
Page 59 of 70
<table>
<thead>
<tr>
<th>Regulation 22: Premises</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>A meeting with Technical Services Manager and Service Manager is scheduled for January 2020 to progress the resolution of difficulties accessing timely preventative and reparative maintenance. A new Maintenance log Template (See same uploaded) has been implemented in Oct 2019 to robustly record the status and resolution of reported maintenance issues. A survey of Selskar House Premises took place on 7th January 2020 and issues will be addressed. Where maintenance issues are not addressed in a timely manner, they will be escalated via the ADON to the Service Manager.</td>
<td>The new Maintenance Log and the resolution of maintenance issues will be monitored monthly as part of the ADON Premises Audit which checks for maintenance issues.</td>
<td>Achievable/Realistic</td>
<td>28/02/2020</td>
<td>ADON/Service Manager/ Technical Services</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>A meeting with Technical Services Manager and Service Manager is scheduled for January 2020 to progress the resolution of difficulties accessing timely preventative and reparative maintenance. A new Maintenance log Template (See same uploaded) has been implemented in Oct 2019 to robustly record the status and resolution of reported maintenance issues. A survey of Selskar House</td>
<td>The new Maintenance Log and the resolution of maintenance issues will be monitored monthly as part of the ADON Premises Audit which checks for maintenance issues. The Maintenance Manager has been invited to attend future Selskar QPSC meetings to offer input into current maintenance</td>
<td>Achievable/Realistic</td>
<td>28/02/2020</td>
<td>ADON/Service Manager/ Technical Services</td>
</tr>
</tbody>
</table>
Premises took place on 7th January 2020 and issues will be addressed. Where maintenance issues are not addressed in a timely manner, they will be escalated via the ADON to the Service Manager.

**Reason ID : 10000717**

The approved centre did not have a suitably sized dining room to accommodate the number and mix of residents, 22(4). The residents' dignity was not appropriately respected at all times because staff were observed to stand over residents to assist with feeding at mealtimes. The residents' dignity was not appropriately respected at all times because two residents had to eat their meals at a table on the corridor across from the dining room due to lack of space.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service management will meet with Technical Services in Jan 2020 to explore viable options for increasing the space for residents to dine. Once additional space has been achieved, the dining space adjacent the dining room will no longer be utilised. Staff are directed to use stools at all times whilst assisting residents with their meals. CNMs oversee same.</td>
<td>QPSC will monitor progress. Additional dining space will be evident when achieved. CNMs will monitor staff's usage of stools at mealtimes.</td>
<td>The scope to enlarge the dining space is not yet known and hence the achievability cannot be determined at present.</td>
<td>31/10/2020</td>
<td>Service Manager/Technical Services/CNMs</td>
</tr>
</tbody>
</table>

**Preventative Action**

Service management will meet with Technical Services in Jan 2020 to explore viable options for increasing the space for residents to dine. Once additional space has been achieved, the dining space adjacent the dining room will no longer be utilised.

<table>
<thead>
<tr>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QPSC will monitor progress. Additional dining space will be evident when achieved. CNMs will monitor staff's usage of stools at mealtimes.</td>
<td>The scope to enlarge the dining space is not yet known and hence the achievability cannot be determined at present.</td>
<td>31/10/2020</td>
<td>Service Manager/Technical Services/CNMs</td>
</tr>
</tbody>
</table>

**Reason ID : 10000718**

The approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff, and visitors, as many of the bedroom door hold back mechanisms were broken, 22(3).
<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hold back mechanisms have now been repaired. The ADON conducts a monthly premises audit which includes checking of same. Where maintenance issues are not resolved in a timely manner, these are escalated to the Service Manager.</td>
<td>Monthly Premises Audit.</td>
<td>Achievable/Realistic</td>
<td>07/01/2020</td>
<td>ADON/Service Manager/Technical Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A meeting with Technical Services Manager and Service Manager is scheduled for January 2020 to progress the resolution of difficulties accessing timely preventative and reparative maintenance. A new Maintenance log Template (See same uploaded) has been implemented in Oct 2019 to robustly record the status and resolution of reported maintenance issues. Where maintenance issues are not addressed in a timely manner, they with be escalated via the ADON to the Service Manager.</td>
<td>Monthly Premises Audit.</td>
<td>Achievable/Realistic</td>
<td>31/01/2020</td>
<td>ADON/Service Manager/Technical Services</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

#### Reason ID: 10000719

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All MDT members are now up to date with MPVA. Fire training is currently 77%. We are awaiting confirmation of further Fire Training for the last week in January 2020 to bring us fully compliant with same.</td>
<td>Mandatory Training Database is updated and monitored by Compliance Officer</td>
<td>Achievable/Realistic</td>
<td>31/01/2020</td>
<td>MDT Members/HODs</td>
</tr>
</tbody>
</table>

#### Preventative Action

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Robust training schedules are now in place (See same uploaded). Monitoring of all MDT members training requirement now takes place and training needs are addressed prior to staff becoming out of date.</td>
<td>Training database is updated and monitored monthly.</td>
<td>Achievable/Realistic</td>
<td>31/01/2020</td>
<td>Compliance Officer/MDT Members/HODs</td>
</tr>
</tbody>
</table>
### Regulation 21: Privacy

**Reason ID: 10000720**

The resident’s dignity was not appropriately respected at all times because one resident's bedroom window was broken and the resulting draft caused the resident discomfort.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The window was repaired.</td>
<td>Monthly Premises Audit.</td>
<td>Achievable/Realistic</td>
<td>07/01/2020</td>
<td>Technical Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A monthly ADON Premises Audit takes place to identify any new maintenance issues. These are recorded on a new Maintenance Log. Resolution of maintenance issues is monitored as part of the monthly Premises audit. Where issues are not resolved in a timely manner, these are escalated to the Service Manager.</td>
<td>Monthly Premises Audit. Maintenance Log is monitored monthly.</td>
<td>Achievable/Realistic</td>
<td>07/01/2020</td>
<td>CNM/ADON/Service Manager/Technical Services</td>
</tr>
</tbody>
</table>
### Regulation 27: Maintenance of Records

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Records were not maintained in good order to ensure completeness, accuracy and ease of retrieval as: not all records had secure pages, 27(1), not all entries included the date, 27(1), not all entries included an accurate date, 27(1), not all entries included the time, 27(1), not all entries included a signature, 27(1)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An audit of all healthcare records will take place on 21/01/2020. Any non compliance with Regulation 27 Maintenance of Records will be addressed. The typed patient summaries which were identified as not being signed, dated or timed will be reprinted, signed, dated and timed.</td>
<td>Regulation 27 Maintenance of Records</td>
<td>Achievable/Realistic</td>
<td>21/01/2020</td>
<td>Compliance Officer/CNM</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Regulation 27 Maintenance of Records Audits will take place quarterly. All non compliance found will be immediately addressed.</td>
<td>Regulation 27 Maintenance of Records</td>
<td>Achievable/Realistic</td>
<td>21/01/2020</td>
<td>Compliance Officer/CNM</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reason ID : 10000713</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A medical examination of the resident was not completed no later than three hours after the start of the episode of physical restraint, 5.4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong>&lt;br&gt;Since this episode of Physical Restraint occurred in Quarter 1 2019, a Physical Restraint Checklist has been developed and implemented which documents that all requirements under the COP Physical Restraint have been completed including the requirement for a medical examination no later than 3 hours after the start of the episode of physical restraint (See same uploaded). The Nurse in Charge now ensures the Physical Restraint checklist and all requirements within it are completed in full for any episodes of physical restraint.</td>
<td>All episodes of Physical Restraint are reviewed by the ADON to ensure they have been carried out in accordance with the COP.</td>
<td>Achievable/Realistic</td>
<td>07/01/2020</td>
<td>Nurse in Charge/ADON/Medical Staff</td>
</tr>
<tr>
<td><strong>Preventative Action</strong>&lt;br&gt;Since this episode of Physical Restraint occurred in Quarter 1 2019, a Physical Restraint Checklist has been developed and implemented which documents that all requirements under the COP Physical Restraint have been completed including the requirement for a medical examination no later than 3 hours after the start of the episode of physical restraint. The Nurse in Charge now ensures the Physical Restraint checklist and all requirements within it are completed</td>
<td>All episodes of Physical Restraint are reviewed by the ADON to ensure they have been carried out in accordance with the COP.</td>
<td>Achievable/Realistic</td>
<td>07/01/2020</td>
<td>Nurse in Charge/ADON/Medical Staff</td>
</tr>
</tbody>
</table>
In full for any episodes of physical restraint.
Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to “visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate”.

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.

b) See every patient the propriety of whose detention he or she has reason to doubt.

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgement Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.